



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: HARRIS METHODIST OF FORT WORTH 3225 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-10-0929-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICA FIRST LLOYDS INSURANCE CO Rep Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "HRA has been hired by Texas Health of Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the Medicare fee schedule for the following HCPC's: **HCPC...97110x15...97001. Please submit this claim for the correct allowable, but per the Medicare allowable at 148%.**"

Amount in Dispute: \$67.25

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Principle Documentation:

1. Response package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
10/15/08 Through 10/31/08	Hospital Outpatient Surgical Services CPT Code 97110GPx15 CPT Code 97001GP	CPT Code 97110 x15: The MAR is \$35.72 x 15 = \$535.80 less previously paid by respondent of \$557.10 CPT Code 97001: The MAR is \$91.32 less previously paid by respondent of \$94.75	\$67.25	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled **Hospital Facility Fee Guideline – Outpatient**, effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and meets the requirements for medical dispute resolution under 28 TAC §133.305 (a)(4).

1. The disputed services were denied or reduced by the insurance carrier based upon:

Explanation of benefits dated 12/16/08 noted claim reduction codes:

- 197 — PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
- W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. THIS SERVICE IS RE-PRICED ACCORDING TO THE TX PHYSICIAN FEE SCHEDULE.

Explanation of benefits dated 03/27/09 noted claim reduction codes:

- W3 — ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- W4 — NO ADDITIOANL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Explanation of benefits dated 08/18/09 noted claim reduction codes:

- 193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

2. The respondent denied disputed service, CPT code 97001 on disputed date of service 10/15/08, with reason code 197 – “Payment denied/reduced for absence of precertification/authorization.” The respondent subsequently reimbursed the disputed service. Therefore, this denial reason is not supported. The disputed service will therefore be reviewed per applicable rules and fee guidelines.
3. Division rule at 28 TAC §134.403 (e) states in pertinent part, “Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables.”
4. Pursuant to Division rule at 28 TAC §134.403(f), “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.”
5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) Separate reimbursement for implantables was *NOT* requested by the requestor.
6. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
7. The requestor lists CPT code 97110GP x15 and 97001GP as the codes in dispute.
8. Pursuant to division rule at 28 TAC §134.403(h), “For medical serviced provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedule, reimbursement shall be made using the applicable Division Fee guideline in effect for that service on the date the service was provided.
9. CPT code 97110GP, billed under Revenue code 0420 has a payment status indicator of A which, per Addendum D1,

signifies a service that is paid under a fee schedule or payment system other than OPPS. The division finds that Medicare reimburses this service using division rule at 28 TAC §134.203(c)(1). Per Division rule at 28 TAC §134.203(c)(1), the MAR for CPT code 97110 rendered in Arlington, TX on the disputed date of service is \$52.83 (workers comp. conversion factor) divided by 38.087 (Medicare conversion factor) = \$1.39 x \$25.70 = \$35.72 (MAR) x 15 = \$535.80. The insurance carrier paid \$557.10.

10. CPT code 97001GP, billed under Revenue code 0420 has a payment status indicator of A which, per Addendum D1, signifies a service that is paid under a fee schedule or payment system other than OPPS. The division finds that Medicare reimburses this service using division rule at 28 TAC §134.203(c)(1). Per Division rule at 28 TAC §134.203(c)(1), the MAR for CPT code 97001 rendered in Arlington, TX on the disputed date of service is \$52.83 (workers comp. conversion factor) divided by 38.087 (Medicare conversion factor) = \$1.39 x \$65.70 = \$91.32 (MAR). The insurance carrier paid \$94.75.

Based on the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c) the Division concludes that the requestor has not established that additional payment is due. As a result the amount order is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403, §133.307, §133.305 and §134.203

PART VII: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

September 21, 2010

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.